SINGLE-PAYER PROPOSAL 'POLITICALLY IMPRACTICAL' 4 | PENCE SEEKS TO REPEAL GUARANTEED ISSUE 12 | MEDICARE Rx COSTLY 10

HEALTH CARE NEWS

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GAO Study: Privacy Protections Are Weak

by Twila Brase, RN

Personal data in the federal government may not be adequately protected from collection, use, and disclosure, according to a report released on July 30 by the United States General Accounting Office.

In the report, *Privacy Act: OMB Leadership Needed to Improve Agency Compliance*, the GAO writes that compliance with the federal Privacy Act of 1974 is generally high in many areas, but uneven across the federal government. "As a result of this uneven compliance, the government cannot adequately assure the public that all legislated indi-

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Illinois Lawmakers Debate Health Plan

by Steve Stanek

A push is underway in the Illinois General Assembly to move the state toward the establishment of a universal health care system.

House Bill 2268 would create a bipartisan Health Care Reform Commission (HCRC) to oversee the gathering of comments from the public and recommendations for a universal-access health care plan. The bill received bipartisan support and this spring passed the Illinois House of Representatives 60-45.

The senate version of the bill (Senate Bill 1430) passed the Senate Health and

ILLINOIS continued on page 14

How Risky Is Maine's Single-Payer Plan?

by Hon. W. Tom Sawyer Jr.

Was passage of Maine's Dirigo Health plan the right solution for the state's health care woes?

Risk theory suggests that before one enters into a risky venture, the upside of success must be greater than the downside of failure. For instance, a risk-benefit analysis would conclude it makes no sense for an amateur to leap off the cliffs at Monaco on a dare by friends. But the very same leap, made by a professional before thousands of reporters and news cameras, could be deemed wise

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Florida Passes Malpractice Reform

KRT

Florida Governor Jeb Bush speaks to more than 2,000 doctors and supporters who gathered in Tallahassee, Florida to protest the high cost of medical malpractice lawsuits. The event was aimed at persuading legislators to cap malpractice damage awards.

Compromise bill ends months of deadlock

by James M. Taylor

After months of squabbling, the Florida House and Senate have reached agreement on legislation capping medical malpractice damages. On August 13 the House passed the compromise bill by a vote of 87-26, and the Senate passed the measure by a vote of 32-4. Governor Jeb Bush then signed the legislation into law.

The new law does not cap economic damages, such as medical bills and lost pay. The measure does, however, cap non-economic damages, such as pain and suffering, at $500,000 per physician and $750,000 per hospital or health care facility.

Two exceptions to the caps are included in the law. The first exception protects emergency room physicians, capping their non-economic damages at $150,000 per physician and $300,000 total (from all practitioners). The second exception allows

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CAPITOL HILL **NEWSWATCH**

Santorum Introduces Tax Credit Measure

Roll Call

Sen. Rick Santorum (R-Pennsylvania) has reintroduced a health care tax credit measure similar to one George W. Bush endorsed in his campaign.

by John C. Goodman, Ph.D.

Senator Rick Santorum (R-Pennsylvania) has reintroduced a bill to create a tax credit for people who buy their own health insurance. The original measure was introduced by now-retired Congressman Dick Armey (R-Texas), and a variation on the measure was endorsed by George W. Bush during his campaign for the Presidency. Fair disclosure: I was personally involved in their efforts.

Santorum's Fair Care for the Uninsured Act of 2003 (S. 1570) was introduced on August 1. Lindsey Graham (R-South Carolina) and Wayne Allard (R-Colorado) have signed on as cosponsors. Among the bill's key features:

- **Fixed Sum**. The credit is dollar for dollar up to $1,000 (for adults) and $3,000 (for families). As a result, the credit would subsidize only core insurance, leaving people free to pay for additional coverage with their own after-tax dollars. Individual insurance buyers would not be able to lower their taxes simply by buying more expensive insurance—a problem that plagues employer-provided insurance.
- **Refundable**. The credit is fully available to everyone who purchases insurance, regardless of whether they pay income taxes.
- **Advanceable**. The Bentson tax credit (circa 1989) was rarely used because low-income families had to come up with the money to pay premiums during the year and file for their tax refund the following April 15. The Santorum measure allows people to get the relief at the time they pay the premiums.
- **Assignable**. To increase the ease of administration, the Santorum bill allows a low-income family to assign its tax credit to an insurer so the insurer can handle all the paperwork.
- **No Income Restrictions**. The Santorum tax credit is available regardless of income. By contrast, the current Bush proposal, as well as other proposals, phase out as family income rises—thus raising effective marginal tax rates.
- **No Supply-Side Restrictions**. There are no restrictions on the type of insurance that can be purchased, such as guaranteed issue requirements that would discourage sales and threaten to undermine the individual market.

Further Improvements Possible

The Santorum measure comes with a budget pricetag. A properly designed tax credit, however, would be budget-neutral, because spending on programs for the uninsured should fall as more people use the tax credit to get insurance coverage. When people claim the credit, the federal government should reduce its payments to the safety nets in those same communities. These reductions should "pay for" the cost of the credit. By contrast, people who reject the tax credit will pay higher taxes, and those taxes should help fund the safety net in communities where they live.

An earlier version of the bill unwisely mandated maintenance of effort on the part of employers—that is, the measure prohibited employers who already provide insurance coverage from dropping it. A better approach is to give people as individuals (or employers deciding for whole groups) the opportunity to choose their own tax regime. That means individuals in employer plans could choose a tax exclusion (the current system) or a tax credit, but not both.

Talking Point

One way to achieve tax fairness and at the same time remove the distorting effect of tax subsidies is to give every taxpayer a tax break that (a) is conditional upon the purchase of insurance but (b) does not increase if the taxpayer chooses more expensive coverage. Employers and their employees would make premium payments and MSA deposits with after-tax dollars, and employees would receive a tax credit for the purchase of insurance on their personal income tax returns.

John C. Goodman, Ph.D. founded the National Center for Policy Analysis in 1983 and has served as president since the center's inception. His email address is **jcgoodman@ncpa.org**.

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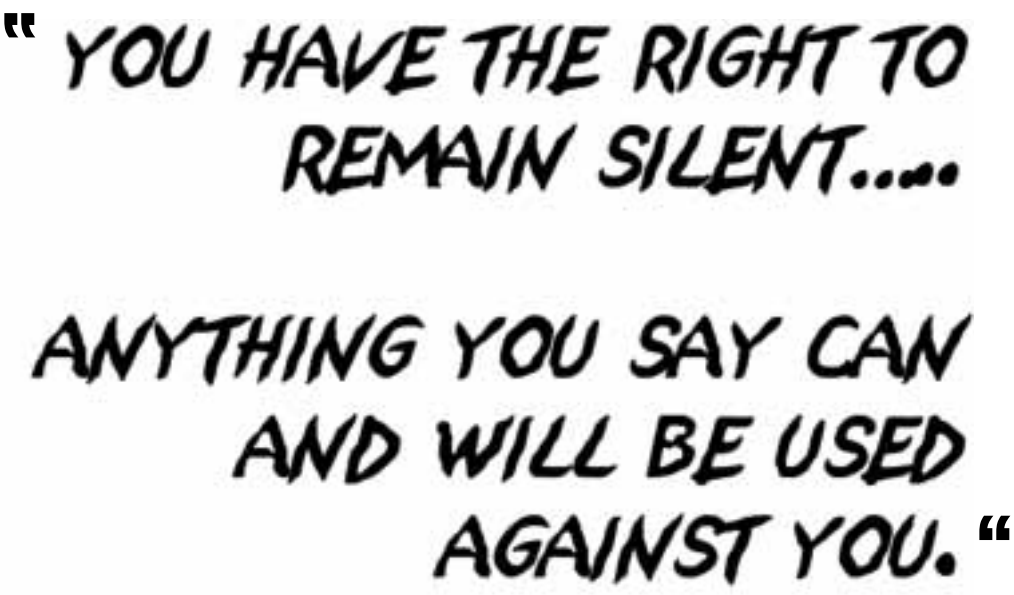

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Single-Payer Proposal Called "Politically Impractical"

Conrad F. Meier

A controversial socialized medicine proposal published in the August 12 issue of the *Journal of the American Medical Association* (JAMA) suggests the federal government should pay all health care bills for everyone living in the United States, effectively putting private insurers out of business and health care providers on the government payroll. The proposal makes no distinction between U.S. citizens and millions of undocumented immigrants.

The proposal's sponsors, Physicians for a National Health Program (PNHP), claim the plan has attracted the signatures of 7,782 supporters, including hundreds of academics, medical school deans, thousands of practicing doctors, and medical students. The plan also is endorsed by former surgeons general Dr. David Satcher, who served under President Bill Clinton, and Dr. Julius Richmond, who served under President Jimmy Carter.

The American Medical Association (AMA), which publishes the journal, was quick to say it does not support the proposal. The insurance industry, which is often at odds with the AMA, also opposes the plan.

Dr. Donald J. Palmisano, president of the AMA, said the association "advocates a solution to the uninsured crisis that builds on the strengths of our current system. By implementing a single-payer system, the United States would be trading one problem for another."

Organizations representing insurers also gave the plan a cold shoulder. Dr. Donald A. Young, president of the Health Insurance Association of America, said, "private insurance offers patients better quality care and greater control over health care decisions than the 'one-size-fits-all proposal' the doctors group put forward."

The proposal comes as many of the 2004 Democratic Presidential candidates have made universal health care coverage a major focus of their campaigns. None of the leading Democratic candidates, however, has stepped forward to fully support the PNHP plan. Only Dennis Kucinich (D-Ohio), former Senator Carol Mosley Braun (D-Illinois), and civil rights activist Al Sharpton have endorsed anything like the PNHP proposal.

In a recent political debate in Philadelphia, Rep. Richard Gephardt (D-Missouri) responded to the plan saying, "The single-payer plan is politically impractical. Oregon voters last fall rejected a single-payer plan by a 4-1 ratio."

Medicare for All

Dr. Quentin Young, a Chicago internist and cofounder of PNHP, and Dr. Steffie Woolhandler, an associate professor at the Harvard Medical School and primary care physician, co-authored the plan. Both were prominent during the failed attempt to pass former President Bill Clinton's universal health care plan. Many of the supporters of the PNHP plan served on Hillary Clinton's Health Care Task Force.

Woolhandler, an outspoken advocate of socialized medicine, wrote last year in the September issue of the *Socialist View Point*, "We pay the world's highest health care taxes. But much of the money is squandered [on administration.] The wealthy get tax breaks. Every other developed nation has national health insurance." Woolhandler also says, "Simply cutting administrative costs could yield $200 billion a year in savings, enough to cover the uninsured and upgrade coverage for Medicare beneficiaries." (See "PNHP 'Factless' on Canadian Health Care," page 6.)

Susan Pisano, a spokeswoman for the American Association of Health Plans, said it is unreasonable to think administrative costs could be reduced as much as the doctors' group says, because many of those costs are imposed by the government.

Linda Gorman, senior fellow with the Independence Institute and director of the Rocky Mountain Center for Health Care Policy, questions Woolhandler's statement as well.

"Market systems reward those who reduce costs by increasing their profits. Government systems offer no such incentive, with the result that single-payer health care is extraordinarily costly to run," wrote Gorman in a January 13 essay.

"Wharton professor Patricia Danzon calculated that with all costs included, the overhead of the Canadian system is about 45 percent of claims," Gorman noted. "Danzon's estimate of overhead for U.S. private insurers, net of government cost shifting, was about 7.6 percent of claims."

According to health actuary Mark Litow, Gorman continued, "Medicare and Medicaid spend about 27 cents on overhead for every dollar of benefits. Private insurers spend about 16 cents. In Oregon, a decade-long attempt to rationalize Medicaid spending by running it like a single-payer system succeeded only in reducing access and doubling spending."

A Threat to Quality Care

The PNHP plan differs from Clinton's 1993 initiative in that Clinton tried to avoid massive tax hikes by shifting the financial burden to employers in a mandate requiring all employers to provide health insurance.

The government's role under the PNHP proposal, as in Canada's health care system, would be to collect whatever additional taxes are needed to pay for universal health care. The arrangement is popularly known as "single-payer" because the government essentially becomes the insurance company, paying all health care bills. That responsibility is currently shared under the U.S. health care system by citizens, the government, and private businesses.

The PNHP proposal would attempt to control costs by setting a national or global budget, rationing money to hospitals for day-to-day operations and major expansions, rationing payments for nursing homes, rationing in-home services for the elderly, and implementing a national prescription drug formulary identifying the only "approved" drugs for which the government would pay.

Gorman warns the single-payer approach seriously threatens the quality of health care and positive medical outcomes that currently set U.S. health care apart from the rest of the world.

"The poor performance of single-payer systems can be seen in cancer mortality ratios, the death rate divided by the incidence of disease," she writes. "For breast cancer, the U.S. mortality ratio is 25 percent. In Canada and Australia it is 28 percent, in Germany it is 31 percent, in France it is 35 percent, and in New Zealand and the United Kingdom it is 46 percent. For prostate cancer, the U.S. mortality ratio is 19 percent. In Canada it is 25 percent, in New Zealand it is 30 percent, in Australia it is 35 percent, in Germany it is 44 percent, in France it is 49 percent, and in the United Kingdom it is 57 percent."

While most hospitals and clinics would remain privately owned and operated under the PNHP plan, the federal health care bureaucracy would control the purse-strings, setting a monthly budget for the facilities' operating costs and paying them no more than that budget. Investor-owned facilities would be converted to non-profit status. Private insurance companies would essentially be eliminated.

One Size Fits No One

Merrill Matthews, director of the Council for Affordable Health Insurance (CAHI), expressed dismay at the PNHP's inability to distinguish between dreams and reality.

"I can understand their desire to provide health care for everyone—that's why they keep proposing this idea," Matthews said. "What I can't understand is why these doctors think a single-payer system achieves that goal. Every country that has enacted a single-payer health care system is in far worse shape than the United States. No government can provide all the care that everyone can effectively use."

Matthews also noted, "When you politicize health care dollars, health care has to compete with other valid claims for government funds, such as education, welfare and defense. There is never enough money to go around."

Greg Scandlen, director of the Center for Consumer Driven Health Care at the Galen Institute, agreed with Matthews' assessment, noting "countries that adopted the approach are racing to change it." And while Americans are registering discontent with the health care status quo, Scandlen points to surveys by Dr. Robert Blendon of Harvard University that show a similar level of discontent among the people of Canada, the UK, Australia, and New Zealand.

"Popular support [for single-payer health care] in Canada has plunged in the past 10 years. These countries now see that a single-payer approach leads to rationed care, high rates of taxation, and the virtual banishment of new technology and innovation. It is time for single-payer advocates to join the twenty-first century and support empowering consumers instead of relying on command-and-control bureaucrats to make decisions for Americans."

Dr. Donald Palmisano, AMA's president, sums up the PNHP plan as one that "... would lead to long lines, an even thicker health-care bureaucracy, and a slowness to adopt new technologies and maintain facilities."

Pisano warned against turning health care over to the government, emphasizing the essential role the private sector plays in health care. "Private industry, not the government, has led the way in adopting disease management programs and prescription drug coverage. Innovation almost always begins in the private sector. It is very difficult for the government to innovate and change with changing times."

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dickgephardt2004.com

Richard Gephardt (D-Missouri) takes time after a house party to answer questions on health care from a New Hampshire voter. Gephardt called PNHP's single-payer proposal "impractical."

"Every country that has enacted a single-payer health care system is in far worse shape than the United States. No government can provide all the care that everyone can effectively use."

MERRILL MATTHEWS, DIRECTOR, COUNCIL FOR AFFORDABLE HEALTH INSURANCE

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Lieberman Proposes New Health Insurance Programs

Conrad F. Meier

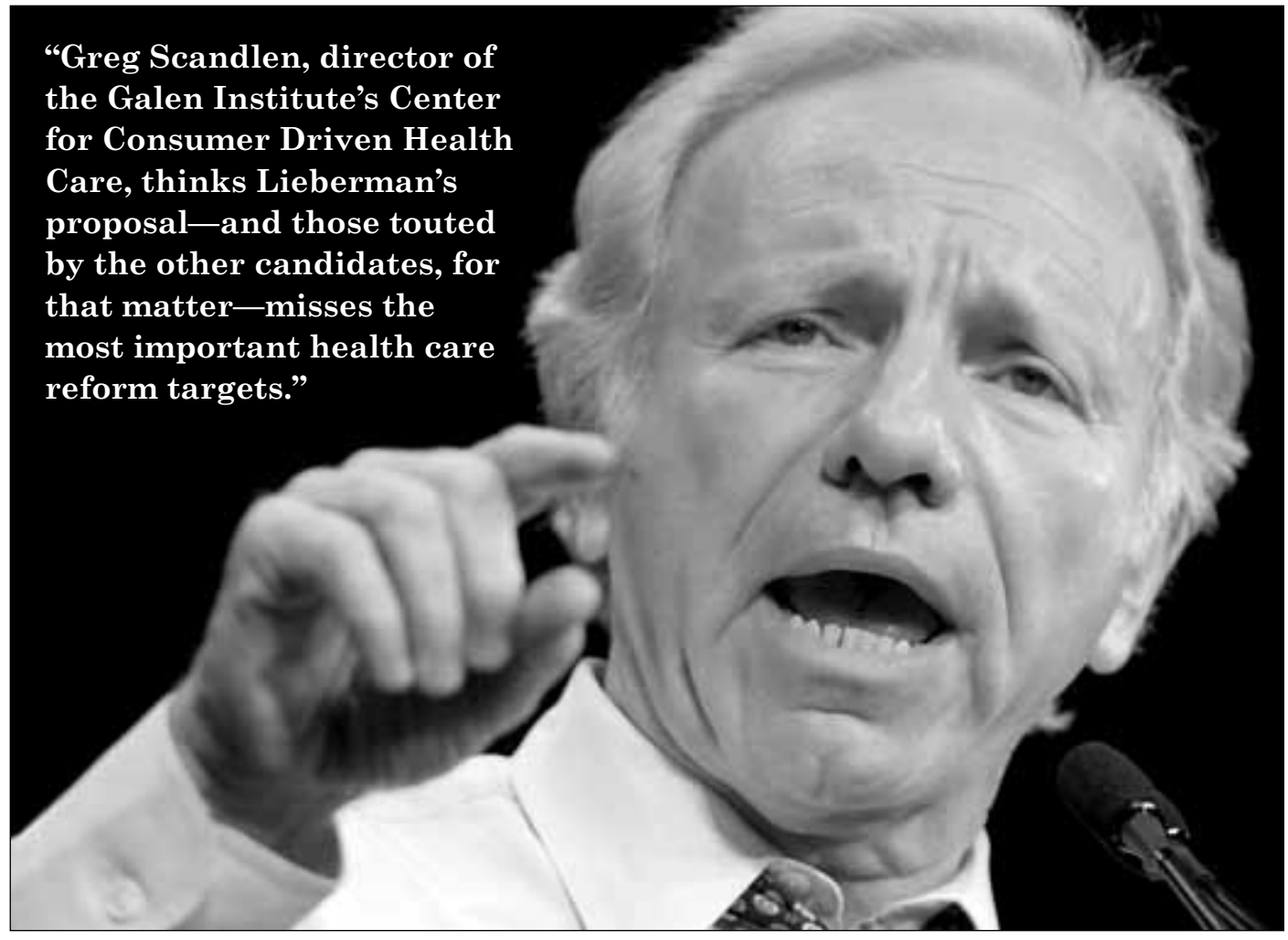
Connecticut Senator Joe Lieberman in August went public with his plans for expanding government intervention into the health care arena, the last of the major Democratic Presidential contenders to weigh in on the issue.

Lieberman's "MediKids," "MediChoice," and "KeepCare" proposals would subsidize health insurance for children, small-business employees, and laid-off workers.

Kenneth Thorpe, a health policy analyst at Emory University, estimated Lieberman's proposals would provide insurance for 31.6 million of the 41 million Americans who lack health insurance, at a projected cost of $53.4 billion a year.

Lieberman told the *USA Today* editorial board he has found widespread anxiety about health care on the campaign trail, especially among those who fear the loss of a job will bring with it the loss of health insurance coverage as well.

According to Lieberman campaign spokesperson Jano Cabrera, the senator would fund his health care proposal by raising taxes—repealing portions of tax cuts implemented by President George W. Bush—and through "savings" Cabrera did not describe. Lieberman says he would not increase the federal deficit to pay for expanded health care programs.



"Greg Scandlen, director of the Galen Institute's Center for Consumer Driven Health Care, thinks Lieberman's proposal—and those touted by the other candidates, for that matter—misses the most important health care reform targets."

AFP

Democratic Presidential hopeful, Connecticut Senator Joe Lieberman, delivers his remarks at the political action conference of the Service Employees International Union (SEIU) on September 8, 2003 in Washington, DC. Citing health care as their number one priority, 1,500 of the most politically active members have come together from across the country to share strategies for the 2004 Presidential elections.

Who's Offering What

A summary of the health care reform measures offered by the principal candidates known to be running for the Democratic Party's 2004 Presidential nomination.

Former Vermont governor Howard Dean: Expand federal and state programs to cover children, low-income adults. Tax breaks to help individuals and small businesses buy insurance. Predicted cost: $93 billion a year.

North Carolina Senator John Edwards: Require parents to provide health insurance for their children. Tax credits would help cover the cost, depending on family income. Predicted cost: $53 billion a year.

Missouri Representative Richard Gephardt: Require employers to offer coverage and give them tax breaks to help pay the cost. Predicted cost: $240 billion a year.

Massachusetts Senator John Kerry: Restructure federal and state programs to cover more children, low-income adults. Tax breaks to help individuals and small businesses buy coverage. Predicted cost: $89 billion a year.

Ohio Representative Dennis Kucinich: Government-run, Canadian-style system to cover everyone. Cost: Unpredictable, but unquestionably the most expensive.

Connecticut Senator Joe Lieberman: Taxpayer-subsidized health insurance for children, small-business employees, and laid-off workers. Predicted cost: $53.4 billion a year.

Lieberman Proposals

- **MediKids**: A program to provide government health insurance to children and young people up to age 25. Families with incomes as much as three times the federal poverty level would be eligible to enroll in the program, which would cover 100 percent of all premium costs. Families with annual incomes above $50,000 would pay premiums estimated at $1,600 a year. MediKids would provide health coverage to approximately nine million uninsured children.
- **MediChoice**: A program to allow self-employed people and the employees of small businesses to buy the private insurance coverage available to federal employees under the Federal Employees Health Benefits Program. Premiums would vary depending on income. Refundable tax credits would be used to ensure no one paid more than 7.5 percent of their income for the coverage.
- **KeepCare**: A proposal to require all employer-sponsored health plans to extend insurance benefits for at least two months after an employee leaves and offer tax credits to cover 65 percent of premiums for workers who choose to extend their coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). KeepCare also would create new tax-subsidized insurance pools through which COBRA recipients and workers receiving unemployment insurance would have access to previous benefits for one year.

According to the Lieberman for President Web site, **http://www.joe2004.com**, both the MediKids and MediChoice programs would try to keep costs down by capping insurance company profits at 2 percent.

Lieberman also would give states the authority and funding to expand Medicaid to adults with annual incomes up to 150 percent of the federal poverty level. Lieberman said he would also seek to establish new networks of health centers in public schools serving families at or near the federal poverty level; would create a national center for curing diseases; and would support parity in coverage for mental and physical ailments. The *New York Times* quoted Lieberman as saying, "Unlike some of the other Presidential candidates, I understand that we don't just need more coverage; we need better care."

Differences

Lieberman told the *Hartford Courant* he wants to build on what works in the nation's current health care system and fix what does not work. He also claimed his plan would have "the lowest cost per person" of any of the plans presented by Democratic Presidential candidates.

According to the *Wall Street Journal*, one of the main differences between Lieberman's plan and those proposed by other candidates is that Lieberman focuses more on subsidizing insurance for the uninsured and less on lowering insurance costs for workers.

Greg Scandlen, director of the Galen Institute's Center for Consumer Driven Health Care, thinks Lieberman's proposal—and those touted by the other candidates, for that matter—misses the most important health care reform targets. "There are many other examples of how badly the current system serves the modern workforce," said Scandlen. "The federal government loses more than $120 billion a year in taxes because employer-sponsored health insurance is tax-free compensation. But there is no tax break at all if you buy your own coverage or pay directly for health care services. Federal tax policy forces us all to rely on our employers for coverage."

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PNHP "Factless" on Canadian Health Care

by John R. Graham and Nadeem Esmail

The August 21 issue of the *New England Journal of Medicine* carries an article claiming the administrative costs of health care in the United States are higher than in Canada: $1,059 (U.S.) in the United States versus $307 (U.S.) in Canada. The lead author, Professor Steffie Woolhandler of Harvard Medical School, co-founder of Physicians for a National Health Plan (PNHP), has written many similar articles over the years, all concluding the U.S. should embrace Canada's system of government monopoly health insurance.

As Woolhandler and her coauthors note, U.S. patients, doctors, and hospitals must deal with multiple insurers, each of which has different policies and paperwork. In Canada, providers must deal with only one, government-run, insurer per province. Woolhandler and her colleagues assert competing private insurers cause high administrative costs, and that a single payer would be able to capture the waste and spend it on patient care. Unfortunately, Canada's experience shows that is not the case.

Facts Overlooked

In 2002, the average Canadian patient waited almost four months from the time his general practitioner decided surgery was necessary until a specialist provided the care. That delay has been growing since 1993, when it was only nine weeks.

Further, Canadians have very little access, relative to other developed countries, to doctors and high-tech imaging machines. In a comparison of access to doctors Canada ranked 17th of 20 countries. Canada ranked of 17th of 22 countries in a comparison of access to CT scanners, 18th of 23 countries for access to MRI machines, and 13th of 14 countries for access to lithotriptors.

Remarkably, this lack of access comes at a high price. After accounting for the fact that Canada has a relatively young population, Canada spends more on health care than all multi-payer OECD countries outside the U.S.—countries such as Germany, Switzerland, and Japan.

Despite these facts, Woolhandler and her PNHP colleagues assume that arbitrarily low administrative costs are the primary indicator of a well-functioning health care system, ignoring other costs imposed by government monopoly. With some of the longest waiting times in the world and age-adjusted health expenditure higher than all other OECD nations with universal health care systems, the Canadian model is clearly not the rousing success it is purported to be.

Low administrative costs, caused simply by government monopoly, do not necessarily reflect a better health care system or low overall costs. Consider the automobile industry: Wouldn't it be cheaper if we got rid of all the salesmen, advertising, marketing, and models that differ in trivial matters such as color? If we all got our cars from the government-run factory wouldn't we have a fairer and cheaper automobile "system"?

They tried that in the Soviet Union and East Germany, and the results were Ladas and Trabants.

Steffie Woolhandler

Facts Ignored

The Woolhandler article also ignores the fact that much of the administrative costs in U.S. health care are created by the federal and state governments. About half of U.S. health care is privately financed, and even that share is subject to an increasing burden of regulation that reduces competition and adds to costs. Private insurers in the U.S. are essentially selling government-mandated policies.

Without competition, providers have little incentive to act in the interests of consumers. Hospitals in Canada do not feel the need to perform more surgeries to reduce waiting lists or to provide higher quality care, because they are secure in the knowledge that patients cannot go anywhere else. Provincial insurers are not concerned with long queues for health services or a lack of access to doctors or technology, because those who pay insurance fees will never stop paying or go elsewhere.

It would be a serious mistake for Americans to opt for a Canadian-style single-payer system considering only the money saved on administration and not the needless suffering and money lost unaccountably through lack of competition. Canadians who take the fact that we spend less than our neighbors on administration as a reason to be smug are making no less serious a mistake.

Increased competition in health care results in better outcomes and higher quality of care for patients. A small increase in health care administration costs in Canada, through the introduction of competition, would be a good thing.

John R. Graham is director of the Pharmaceutical Policy Research Centre, and Nadeem Esmail is a health policy analyst, at the Fraser Institute. Their email addresses are, respectively, **johng@fraserinstitute.ca** *and* **nadeeme@fraserinstitute.ca**.

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"Costs of Health Care Administration in the United States and Canada," by Steffie Woolhandler, T. Campbell, and D.U. Himmelstein, was published in the August 21, 2003 issue of the *New England Journal of Medicine*. The article is available for purchase ($10 in either HTML or PDF format) from the *Journal*'s Web site at **http://content.nejm.org/**.

Survey Documents Doctor Burnout in Canada

by Conrad F. Meier

The Canadian Medical Association (CMA) warns "an alarming number of Canadian doctors are so exhausted, cynical, and stressed out that they are suffering from advanced stages of burnout."

About 2,250 doctors responded to more than 8,000 questionnaires the CMA distributed among its 55,000 members between February and June 2003. The survey results, recently released to the Winnipeg media, add to growing concern physicians are ignoring their own health advice, pushing themselves too hard and failing to seek treatment for illnesses.

Among those responding, the survey found 46 percent suffering from burnout. Researchers evaluating the survey results noted that is only slightly worse than in the general population, but they also expressed concern about some disturbing comments doctors added on their own.

According to the CMA, one doctor wrote, "I'm silently burning out inside, and finding work less rewarding. I would quit medicine, but I'm trapped."

CMA President Dr. Dana Hanson suggested a major source of frustration for doctors has been watching the degradation of the Canadian single-payer health care system. Hanson said, "Often times we are there at the front lines, trying to make up for deficiencies in a system where we're not even asked how we might do that, or change it. So those are the sorts of feelings of frustration that eventually build up."

Karen Palmer, public health reporter for the *Toronto Star*, writes the survey shows doctors are "frustrated by an inflexible, bureaucratic health system that has heaped more patients with more complex problems on fewer physicians."

Dr. David Gratzer, a Canadian physician and author, writes in *Code Blue: Reviving Canada's Health Care System*, "The most important step toward renewing health care in this country is to accept that [single-payer] medicare is fundamentally flawed. As long as politicians cling to the notion that medicare has worked well in the past and that, with the right amount of tinkering, it will work well in the future, these 'reforms' have as much hope of succeeding as the alchemists had of making gold from lead."

Many doctors quietly endure the failings of the single-payer system. Their frustration, says Michael Kaufmann, medical director of the Physician Health Program in Toronto, leads to depression, alcoholism, drug abuse, and marital problems. "Those who can't continue under such conditions," says Kaufman, "drop out of the profession."

"There's a national manpower issue here," Kaufmann added. "We don't want to lose doctors, but some are actually choosing to leave medicine because of these feelings. Medicine is a wonderful, honorable, joyous profession, and I see this in the trainees as they graduate. Then I watch their enthusiasm disappear over time. It's a great tragedy."

"The collective well-being of the Canadian health care system is inextricably linked to the health of its physicians," said Hanson. "Many of our interactions with patients are vital and personal and require the best attitude and mental health of the person. We were surprised, very surprised, at the magnitude of these figures. This recent research is only the starting point of much more that needs to be done."

The CMA says it will devote $50,000 to further study the issue.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

For more information see "Canadian Health Care Fails Five Ways," by Dr. David Gratzer, *Health Care News*, April 2002.

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Anti-MSA Report a Rehash of Old Falsehoods

by Greg Scandlen

Ya gotta give 'em credit. Ten days after the Health Savings Account/Health Savings Security Account (HSA/HSSA) provisions were passed in Ways and Means, the left-leaning Center on Budget and Policy Priorities (CBPP) was out with three separate papers and press releases explaining how these ideas would be the ruination of civilization, destroy the employer-based system of health insurance (of which CBPP is so fond), and create massive deficits in state government (not that the states need any help in creating deficits).

In a news release dated June 26, 2003, CBPP predicts enactment of the HSA/HSSA provisions would "encourage employers to replace traditional health insurance plans with plans that offer fewer benefits and impose higher deductibles and co-payments."

It's difficult to argue with that. But, the news release goes on to repeat the old threadbare and discredited assertions that "Younger, healthy individuals would tend to come out ahead," leaving older, sicker, and lower-income workers worse off.

"[The CBPP's anti-MSA report] simply repeats all the old falsehoods CBPP has been spreading for years now. It relies on sloganeering instead of analysis of actual events."

Opposed to MSA Expansion

The first paper focuses on the medical savings account (MSA) expansion provisions of the Ways and Means amendment. It was able to be written so quickly because it simply repeats all the old falsehoods CBPP has been spreading for years now. It relies on sloganeering instead of analysis of actual events.

It says, "Proponents of large-scale [MSA] expansion argue it would increase health insurance coverage and thereby reduce the ranks of the uninsured. But most health analysts disagree." The assertion that "most" disagree is, of course, unsubstantiated, and disregards the reality that some 75 percent of new MSA accounts go to people who were previously uninsured.

The paper goes on to say widespread use of MSAs could double the premium for "traditional health insurance," by attracting the healthy and wealthy away from traditional coverage. Of course, it doesn't define what is meant by "traditional health insurance." Are health maintenance organizations (HMOs) considered "traditional" health insurance these days? Preferred provider organizations (PPOs)? Point of service (POS) plans?

If the CBPP authors mean "traditional" major medical policies, their criticism is a bit out of date, as such policies have already nearly disappeared from the market. The paper cites the RAND Corporation, American Academy of Actuaries (AAA), and Urban Institute as sources for the notion.

In fact, RAND concluded wealthy people would prefer HMO coverage over MSAs, and the Urban Institute said, "on average, lower-wage workers would benefit from switching to a catastrophic/MSA plan." The AAA report hedged its bets because it couldn't tell if workers would see the MSA funds as their own money, or their employer's money.

It is pretty clear now that MSA account holders correctly view the MSA funds as their own money, and they are careful with those funds.

The reports CBPP relies on were mostly written before the MSA law went into effect, so are entirely speculative and have been disproved over the years of MSA and health reimbursement account (HRA) experience. There is no evidence whatsoever that adverse selection occurs. There is plenty of evidence that MSAs allow people to afford coverage for the first time, and lower the numbers of uninsured. The CBPP worries about employers shifting to less-comprehensive coverage, but employers are doing that anyway, with or without MSAs.

At least MSAs (and HSSAs and HRAs) enable workers to pay their out-of-pocket expenses with tax-favored dollars. The notion that employers will go back to first-dollar coverage in light of double-digit premium hikes is nothing but fantasy. In fact, it is first-dollar coverage that is creating double-digit premium hikes in the first place. Employers are unlikely to repeat that mistake. The other papers are unsurprising and predictable.

In a nutshell, any decrease in tax revenue is seen by CBPP as a bad thing, as is any expectation that consumers should pay some portion of their own medical expenses.

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* **gmscan@aol.com**.

INTERNET INFO

The news release and reports issued by the Center on Budget and Policy Priorities are available on the group's Web site at **http://www.cbpp.org**.

"MSAs Can Be a Windfall for All," written by Greg Scandlen for the National Center for Policy Analysis in November 2001, rebuts the anti-MSA charges that appear in CBPP's work. The paper is available on NCPA's Web site at **http://www.ncpa.org/pub/bg/bg157/**.

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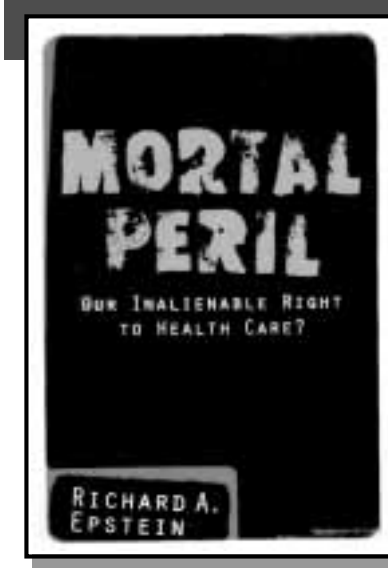

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Florida

Continued from page 1

greater recovery in the most egregious cases, capping recovery at $2.5 million—$1 million from physicians and $1.5 million from hospitals or other health care facilities.

Notably missing in the final bill was a mandatory reduction in malpractice insurance rates. After contemplating a provision that would require insurance companies to immediately lower malpractice insurance premiums, the legislature decided not to include the requirement, out of fear the mandate would be nullified by the courts for interfering with preexisting contracts between doctors and insurers. Instead, the legislation freezes insurance rates for the remainder of 2003 and allows the legislature to impose mandatory cutbacks after January 1, 2004.

Government Officials Happy

Dr. John Agwunobi, head of the Florida Department of Health, praised the legislation as a much-needed solution to skyrocketing medical malpractice insurance rates.

"It assures that over time our system won't collapse under the weight of an exploding medical-malpractice crisis," he said. "We'll be OK."

"This situation is especially critical for women in Florida," Bush had said in a June 9 letter to constituents. "Doctors and hospitals close or limit their obstetrics practices and reduce mammography services. As a result, some women in our state are forced to wait as long as 150 days for access to this important screening procedure, losing the opportunity for early detection of problems."

"I think in the foreseeable future, it will have a calming effect that we've reached a compromise and a bill is now ready to become law," Bush said of the new legislation. "The access-to-care issues that have become more and more serious, I think, will begin to subside.

"I'm confident there will be a reduction in insurance premiums," Bush added. "I'm confident that we'll have a better system to deal with the small number of doctors that commit egregious malpractice."

"I know this legislation will serve its intended purpose and bring relief to physicians, keep insurance companies writing policies in our state, and protect victims of medical malpractice," said Senate President Jim King.

Bitter Wrangling Over

Prior to final passage of the bill, King had been a constant thorn in Bush's side. Bush had spent the better part of a year calling on Florida's Republican-controlled legislature to pass malpractice reform. While the House supported Bush's proposal for a $250,000 hard cap on non-economic damages, Senate Republicans preferred not to act on the issue, or to pass weaker legislation capping non-economic damages at closer to $1 million per plaintiff. Only after Bush called three separate summer legislative sessions did the House and Senate agree on a compromise measure.

Frustrated by the Senate's inaction, word leaked that Bush had encouraged campaign donors to withhold donations to Republicans who were opposing malpractice reform. Nevertheless, once the measure passed King appeared willing to put any bad blood behind him.

"There was a time I wasn't really sure this would ever occur," said King. "I hope whatever wounds there are, they are quick to heal."

"It's a good bill, a bill with a lot of blood, sweat, and tears in it," said Rep. Allan Bense (R-Panama City), who is expected to become House speaker in 2004.

"I'm confident there will be a reduction in insurance premiums. I'm confident that we'll have a better system to deal with the small number of doctors that commit egregious malpractice."

HON. JEB BUSH
GOVERNOR

Not Everyone Pleased

Although most legislators appeared to be satisfied with the compromise bill, few stakeholders appeared genuinely pleased with the outcome.

Many physicians believed too much was given away in the compromise, such that insurance premiums will remain at or near their current rates.

Robert Cline, a Fort Lauderdale heart surgeon and president of the Florida Medical Association, described the bill as "not ideal. But the bottom line is we think some of the things will help."

"I absolutely agree we don't give enough relief to the doctors," added Senator Mike Bennett (R-Bradenton).

The legislation "is about what I expected," said Dr. Frank Skilling, a Tallahassee eye surgeon. "I don't think it's going to get at the heart of the problem, which is that medical malpractice insurance has become prohibitively expensive."

Trial lawyers were incensed at the cap on non-economic damages and vowed to challenge the law as soon as possible after it takes effect, on September 15.

"If I sign this bill at 3:45, my guess is that at 3:46 they'll be in front of a judge somewhere, beginning that process," Bush told reporters at a news conference. But he expressed confidence the legislation would survive a court challenge.

Miami attorney Neal Roth, a former president of the Academy of Florida Trial Lawyers, predicted insurance companies would simply increase their profits as a result of the legislation and would not lower insurance premiums. Roth also asserted the bill fails to assure adequate compensation for the victims of medical malpractice.

"We will be ready to challenge it at the appropriate time," asserted Roth. "You have to wait until September 15. A case will emerge sometime after that. If it's the right case with the right facts and fairly compelling damages, so standing to sue can be established, that's when it will occur. I hope it won't be too long."

James M. Taylor is a lawyer in Florida and managing editor of Environment & Climate News. *His email address is* **taylor@heartland.org**.

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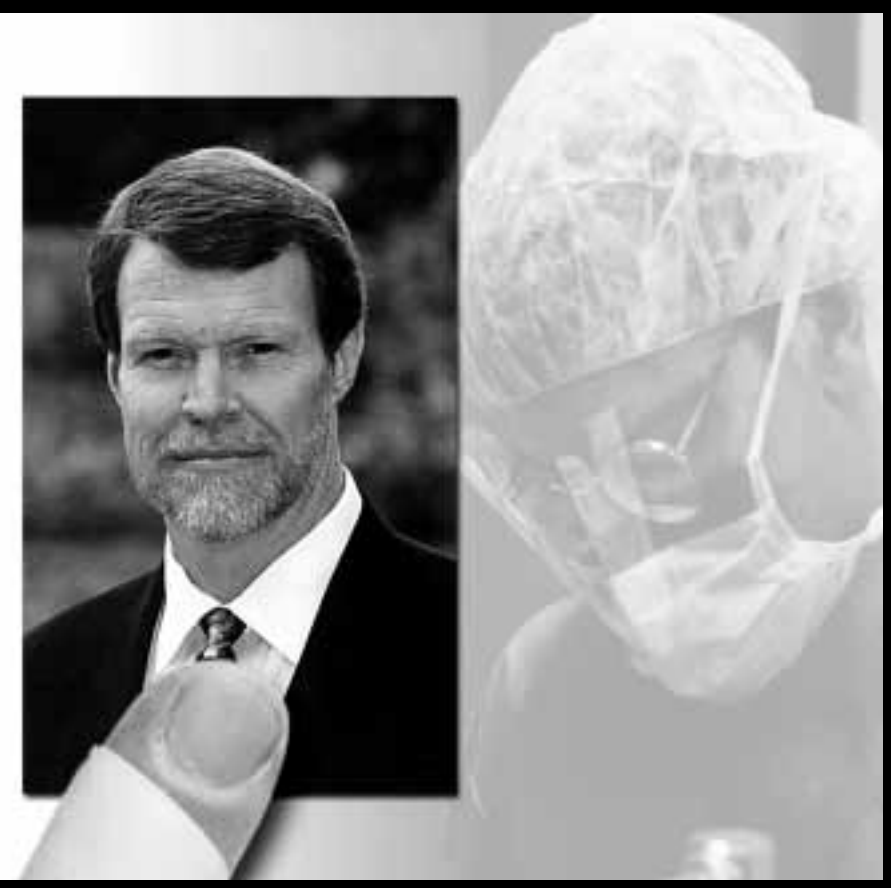

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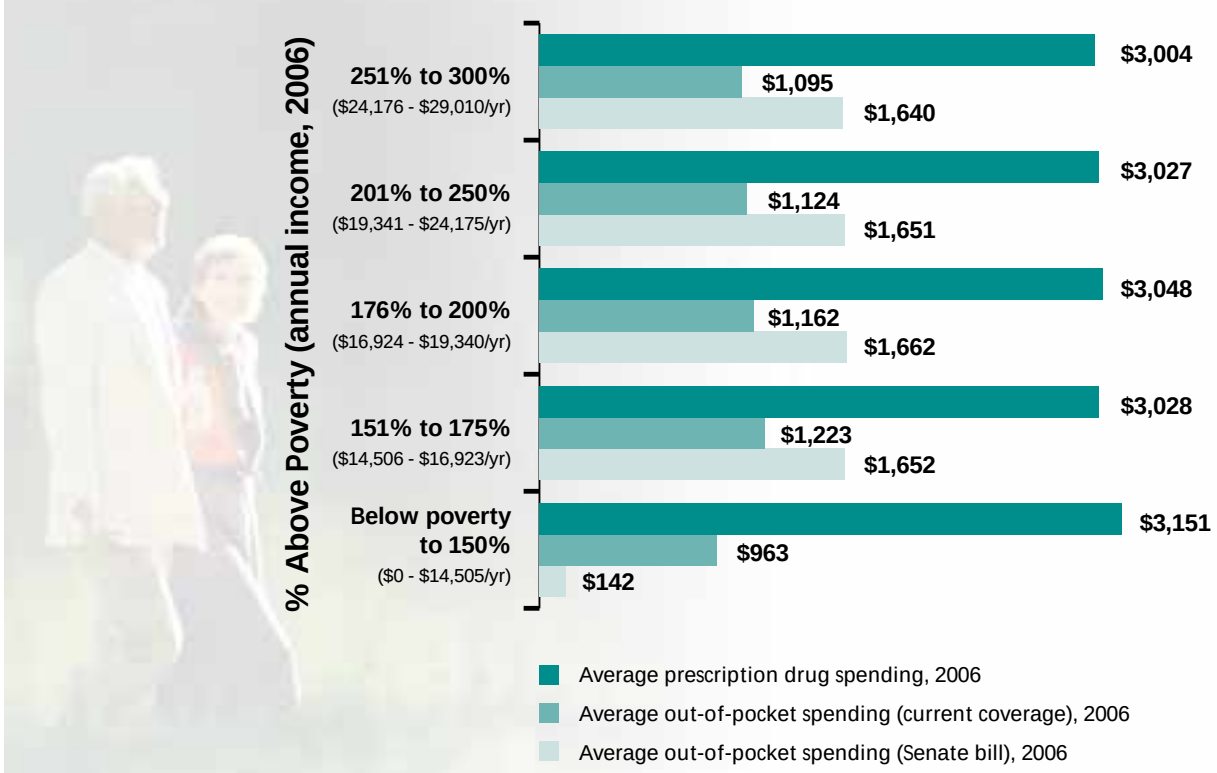
Senate Drug Bill Expensive for Seniors

by Lanhee J. Chen

Out of Pocket Costs Will Increase for Many Low-Income Medicare Beneficiaries Who Currently Have Drug Insurance



Many Medicare beneficiaries could pay up to 50 percent more for their medicines—in some cases $600 more per year—under the Senate's Medicare drug entitlement.

Unfocused Drug Benefit

While some Medicare beneficiaries lack coverage for prescription drug costs, many have at least some form of insurance to cover those expenses. For example, nearly one-third of Medicare-eligible retirees received some form of health insurance coverage from their former employers in 1999. Retiree health insurance coverage often includes generous coverage for prescription drugs.

At present, seniors who have prescription drug benefits from their former employers are able to fill their prescriptions upon payment of a small co-payment (usually less than $10 per prescription) or a minimal yearly coinsurance amount.

The Medicare legislation enacted by both the House and Senate threatens to shrink dramatically the number of beneficiaries who currently enjoy employer-provided prescription drug benefits. This is especially the case with the Senate legislation (S. 1). The Congressional Budget Office (CBO) estimates 37 percent of Medicare beneficiaries with existing prescription drug coverage stand to lose their benefits if the Senate proposal becomes law.

That means millions of seniors would be dumped, regardless of their personal preferences, into the new Medicare entitlement. While this would help them pay for their medicines, it would also increase—in some cases significantly—the amount of money they would pay out-of-pocket.

Senate Budget Committee Analysis

Senate Budget Committee staff, using data and analysis supplied by the Centers for Medicare and Medicaid Services (CMS), recently completed a study of the impact of the Senate Medicare legislation on seniors' out-of-pocket costs. Their analysis estimates the out-of-pocket costs Medicare beneficiaries with existing drug coverage would have to pay under the Senate bill in 2006 (the year the prescription drug benefit would take effect) and compares this figure with the amount beneficiaries would pay in 2006 under their existing drug coverage.

CMS estimates the average Medicare beneficiary with existing prescription drug coverage will consume approximately $3,080 worth of prescription drugs in 2006. With existing prescription drug coverage, that senior would pay, on average, $1,057 in out-of-pocket costs (plus any plan premiums) for prescription drugs in 2006.

Under the Senate Medicare proposal, the average Medicare beneficiary would pay approximately $1,678 in out-of-pocket costs (plus plan premiums) for prescription drugs during 2006—an increase of almost 60 percent over the amount they would pay under their existing drug coverage.

The extra $621 the average Medicare beneficiary will have to spend on prescription drugs in 2006 is more than the average American spent in 2001 on dairy products, fruits and vegetables, cereals, and bakery products combined.

While the poorest Medicare beneficiaries would see some improvement in their out-of-pocket costs under the Senate bill, many low-income seniors would see their prescription drug costs rise.

Take, for example, the Medicare beneficiary who has existing prescription drug coverage and whose annual income in 2006 will be somewhere between $14,506 and $16,923. Under his/her existing prescription drug plan, that senior would pay an average of $1,223 in out-of-pocket costs for prescription drugs during 2006. Under the Senate bill, the senior's out-of-pocket costs would rise approximately 35 percent, to an average of $1,652.

The news is even worse for seniors who make slightly more money: A Medicare beneficiary with existing drug coverage whose annual income in 2006 is between $19,341 to $24,175 can expect to pay, on average, more than 50 percent more in out-of-pocket costs for prescription drugs under the Senate Medicare proposal. (See accompanying graph.)

Hurting Seniors

The Senate Medicare bill would cost federal taxpayers almost $400 billion ... yet it might actually *hurt* more seniors than it would help. Rather than targeting a prescription drug benefit to those who really need it, members of Congress in both houses have chosen instead to pass a universal entitlement that would end up costing millions of seniors significantly more than they pay now. Seniors can only hope this flawed approach doesn't survive conference committee negotiations.

Lanhee J. Chen is Winnie Neubauer Visiting Fellow in Health Policy Studies at The Heritage Foundation. *This article, first published on July 15, 2003 as WebMemo #312, is available on the Internet (with footnotes) at* **www.heritage.org/Research/HealthCare/wm312.cfm**.

Talking Point

The Medicare reform legislation now under discussion in Congress has set the stage for a repeat of one of history's most obvious policy-making blunders. While opinion polls report the public's concern over the health care system as a whole and Medicare in particular, federal legislators have moved ahead on a schedule that appears to be set more by political priorities than by sound policy considerations.

According to Sue Blevins, founder and president of the Institute for Health Freedom in Washington, DC, "Congress seems to be reacting to what it thinks is the public's overwhelming demand for more government regulation and intervention into the Medicare program."

But, Blevins notes, citing a recent survey released by the Galen Institute, "66 percent of respondents said they are worried a government-provided prescription drug benefit might mean some people could lose their private health care coverage and become dependent on government funding."

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Medicare Reform Between a Rock and a Hard Place

by Grace-Marie Turner

Attention to Medicare reform has shifted since Congress left town for the August recess. Medicare dominated the summer debate, but enthusiasm has waned for the House and Senate bills as details have become clearer, especially about the drug benefit.

The August blackout has pushed energy issues to the top of the congressional docket. In addition, the growing danger in Iraq, the California recall election, and the Democratic Presidential race are competing for the nation's attention. This could mean the imperative to pass a major Medicare bill is waning.

With every passing day, political calculations become more important than policy decisions. A Medicare bill passed the Senate largely because Democrats decided to participate in a serious process to get a bill written. Will Democrats recalculate the odds now that their constituents have seen the details of the drug benefit? Some might conclude they could make bigger political gains by promising a better benefit if they were in control.

That's not to say the policy issues aren't tremendously important—they are. But negotiations over fallbacks, premium support, prescription drug reimportation, and rural issues aren't the only considerations.

Two Big Issues

First there is the creation of a new prescription drug benefit, followed by an opportunity to make critically needed improvements in the Medicare program. Few in the general public are aware these are two very separate issues.

There is a huge opportunity here to make progress on modernizing the outdated Medicare program—a prospect many members oppose—but the price will be a drug benefit, which other members don't like.

Harvard Professor Bob Blendon observes, "Congress is between a rock and a hard place. Seniors will be critical of Congress if it does not pass a prescription drug bill, but unhappy if it passes either of the current bills."

On overall Medicare reform, the public is not demanding structural changes because the average person doesn't see much wrong with the program today.

As a result, Senator Edward Kennedy (D-Massachusetts) can be expected to continue to hold his ground against reform. At the same time, it's difficult to see Ways and Means Chairman Bill Thomas (R-California) giving in on his visionary goal, shared with Billy Tauzin (R-Louisiana) and others, of making Medicare a modern and competitive program.

Compromise in the Offing

Does that mean we have a stalemate? With a Republican President and Senate and House leaders all determined to get a final bill, I discount critics who say nothing will pass. President Bush, Speaker Dennis Hastert (R-Illinois), and Majority Leader Bill Frist (R-Tennessee) may wind up being primary players in the final negotiations. They can, I believe, get a bill.

> **"Congress is between a rock and a hard place. Seniors will be critical of Congress if it does not pass a prescription drug bill, but unhappy if it passes either of the current bills."**
>
> BOB BLENDON, PROFESSOR
> HARVARD UNIVERSITY

But they will need to settle on where they can find a respectable amount of bipartisan agreement. The final compromise may be scaled back from the 2,000 pages of legislation now on the negotiators' table.

It could include: 1) a more targeted drug benefit primarily for low-income seniors without coverage, especially those with large drug bills; 2) a pilot or demonstration project for a new competitive Medicare program; and 3) some reforms, like disease management, to make traditional Medicare better, with more money to providers and existing plans.

This could mean the 108th Congress makes a down payment on Medicare reform, with more to come.

Grace-Marie Turner is president of The Galen Institute. Her email address is **gracemarie@galen.org**.

Gingrich to Address 21st Century Medicare

The Institute for International Research (IIR) has announced Newt Gingrich, founder of the Center for Health Transformation, will keynote its Medicare Financing and Product Development Congress being held December 8-10, 2003 at the Loews L'Enfant Plaza in Washington, DC.

Gingrich will discuss "creating a twenty-first century Medicare system"—a system he says will produce higher quality care at a lower cost by featuring increased consumer choice.

Other speakers scheduled for the event include Daniel Crippen, former director of the Congressional Budget Office; Richard Bringewatt, president and CEO of the National Chronic Care Consortium; Dr. Dana Gelb Safran, director of the Health Institute at Tufts-New England Medical Center's Division of Clinical Care; and Dr. Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management at Harvard University.

Dr. Murray Ross, director of health policy analysis and research for the Kaiser Permanente Institute for Health Policy and former executive director of the Medicare Payment Advisory Commission, will chair the event.

The three-day event, aimed at Medicare payers and health care providers, will offer case studies and panel discussions with industry leaders. The promoters say it's a must-attend event for health insurance carriers, who will get "the tools they need to implement strategies to improve their market share and increase profitability of their Medicare business units."

The program will address industry-wide concerns, including the impact of an outpatient drug benefit, the emerging role of pharmacy benefit managers, and revenue generation in the private supplement and Medicare select insurance market. Conrad F. Meier, managing editor of *Health Care News* and senior fellow in health policy for The Heartland Institute, will moderate a panel discussion on the Medicare drug benefit.

Two luncheons and an evening cocktail reception will give the event's speakers and attendees extensive networking opportunities.

INTERNET INFO

Delegates may register for the Medicare Financing and Product Development Congress by calling toll-free 888/670-8200 (within the United States) 941/951-7885 (international). Mention registration priority code XHCN1.

For more information, visit the Web site of the Institute for International Research at **http://www.iirusa.com/medicare** or contact Marketing Director Tosha Wesley at 212/661-3500, ext. 3069.

Medicare Stalls, Seniors Don't Care

by Conrad F. Meier

Republican members of the conference committee charged with reconciling differences in the House and Senate Medicare bills (H.R. 1 and S. 1) were disrupted by an ongoing spat between Senate Finance Committee Chair Charles Grassley (R-Iowa) and House Ways and Means Committee Chair Bill Thomas (R-California).

Grassley told Congress/AM Daily he withdrew his staff from the conference process because he wants negotiators to begin talks on the provisions in both bills that would allocate at least $25 billion to increase payments to rural Medicare providers.

Grassley said aides to Thomas, who as head of the conference committee sets the agenda, told Senate staffers they are not permitted to discuss such payments. Grassley believes Thomas is stalling in order to gain leverage in the negotiations.

No staff-level meetings to discuss reconciling the two bills have been scheduled, and a full conference committee meeting expected in early September was never scheduled.

A spokesperson for the House Ways and Means Committee said negotiators have come to agreement on only one-third of a final bill, including much of the language for a temporary drug discount card, a series of changes to provider appeals, and other regulatory reforms.

Seniors Skeptical

While the pushing and shoving continue on Capitol Hill, pollsters examined the cool reception seniors gave to the House and Senate Medicare prescription drug benefit proposals.

According to a September *USA Today*/CNN/Gallup poll of 1,009 adult Medicare beneficiaries, seniors are skeptical Medicare would be able to effectively deliver a prescription drug benefit.

Seventy-six percent of those responding said they believe the Medicare reform proposals would not do enough to help seniors pay for prescription drugs, while 15 percent said the reform proposals would do enough to help seniors.

Forty-three percent said the proposed Medicare changes would have no effect on their current situation. Twenty-seven percent said the proposals would make their situations worse, and 26 percent said the bills would improve their situations.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Pence Measure Would Repeal Guaranteed Issue Mandate

by Conrad F. Meier

Legislation introduced on July 24 by Rep. Mike Pence (R-Indiana) would lift from the Health Insurance Portability and Accountability Act (HIPAA) a "guaranteed issue" mandate that requires insurance companies offering coverage in the small group market to accept every small employer that applies for coverage.

Pence's H.R. 2851, the Small Business Health Insurance Act, has attracted 18 cosponsors. He says the measure would make health insurance more affordable for small businesses.

"Most small businesses simply cannot afford to purchase insurance at the current rates," Pence noted in a news release announcing the introduction of his bill. "Guaranteed issue in the small group market means that all small employers can get health insurance at any time. While this sounds good, it provides an incentive for healthy employer groups to take their money out of the health insurance system and sit on the sidelines.

"The Small Business Health Insurance Act will eliminate the guaranteed issue mandate, bringing healthy groups back into the system and bringing down the overall cost of health insurance in the small group market."

Pence's measure attracted praise from the Coalition Against Guaranteed Issue (CAGI).

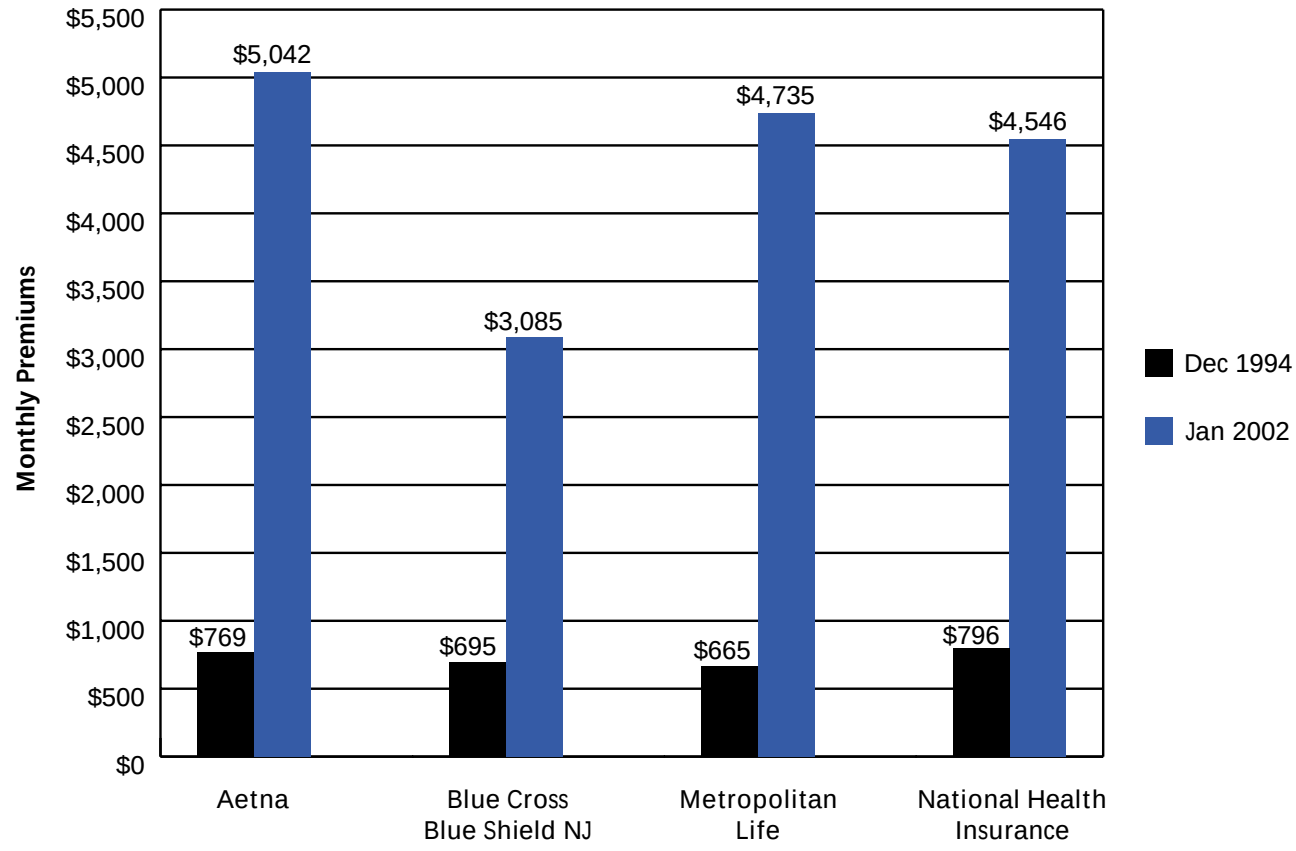
"The Pence initiative will strike down the leading cause of high health insurance premiums for small employers," predicted Greg Kelly, CAGI executive director.

"The Small Business Health Insurance Act will eliminate the guaranteed issue mandate, bringing healthy groups back into the system and bringing down the overall cost of health insurance in the small group market."

HON. MIKE PENCE
REPRESENTATIVE (R-INDIANA)

What Happens to Monthly Premiums Under Guaranteed Issue

New Jersey, 1994 - 2002



Note: Out of 22 companies that have sold family ("Plan D") policies, these four have participated from 1994 to 2002

Source: State of New Jersey (www.state.nj.us/dobi/reform.htm)

Guaranteed Distortions

"Under guaranteed issue," Kelly explained to *Health Care News*, "an individual who has no insurance and becomes ill may apply and be guaranteed insurance benefits. This is comparable to buying auto insurance for a car wreck after the wreck, or buying homeowners insurance while your house is burning down."

CAGI, a coalition of more than 30 companies and organizations, was established in 2002 in response to a guaranteed issue provision built into the trade bill. The group educated members of Congress about how guaranteed issue has disrupted the small group insurance market and is directly related to the rise in the number of uninsured Americans. The guaranteed issue provision was removed before the trade bill passed.

As CAGI points out, states that have passed guaranteed issue mandates now suffer from some of the highest premium costs in the nation, and their populations have higher uninsurance rates than elsewhere in the country. For example:

- A family living in Portland, Maine pays a minimum of $1,176 a month for a preferred provider (PPO) policy with a $500 deductible. In Trenton, New Jersey, a family would pay at least $3,576 a month for comparable coverage. In New York, PPO or indemnity plans (where patients pay the providers themselves and then are reimbursed by their insurance companies) are not even available, so a family living in Ithaca would have the choice of just one policy, a health maintenance organization (HMO) more restrictive than the other plans, costing $1,113 a month.
- In states without guaranteed issue mandates, health insurance is much more affordable. Average families can purchase a $500 deductible PPO policy for $410 a month in Arlington, Virginia; $427 a month in Indianapolis, Indiana; or $479 a month in Chicago, Illinois.

Federal Mandate Even More Dangerous

The growing number of Americans without insurance has become a rallying point for the advocates of single-payer health care, including a host of Democratic Presidential candidates. (See "Single-Payer Proposal Called 'Politically Impractical,'" "Lieberman Proposes New Health Insurance Programs," and "Who's Offering What" in this issue.)

But guaranteed issue, according to Kelly, is not the way to address that problem.

When people know they are guaranteed to qualify for health insurance even after they get sick, Kelly explains, they will cancel current policies or stay out of the insurance market entirely, so long as they are healthy. As a result, the "health insurance risk pool" gets smaller and sicker. As the risk pool shrinks, premiums rise, eventually driving out the population that can least afford the increase yet often have the greatest need for health insurance.

"Many insurers reach the point at which they are no longer able to offer insurance in such a chaotic and economically hostile environment," Kelly observes. "The end results are inordinately high prices for insurance, considerably reduced choices for coverage, a greater number of uninsured and, ultimately, a health insurance market wherein many, if not all, insurers stop offering coverage.

"We cannot afford to enact federal guaranteed issue reforms that would ruin the health insurance market for everyone," warns Kelly.

"Many in Congress believe the only way to assure health insurance coverage and choice is to require guaranteed issue. On the contrary, guaranteed issue will destroy the basic risk classification principles of insurance and only exacerbate the problem of the uninsured."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

For more information on the Pence legislation go to **http://www.cagionline.org/pence.php**. You can also download the bill, in Adobe Acrobat's PDF format, from The Heartland Institute's online research database, *PolicyBot*. Go to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for document **#12881**.

A May 2002 *Issues and Answers* paper prepared by the Council for Affordable Health Insurance addresses state guaranteed issue mandates. See "What Were These State Thinking," at **http://www.cahi.org**.

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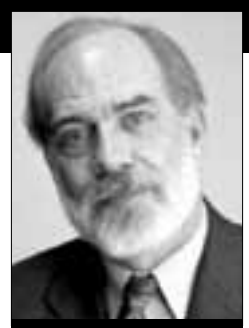

Greg Scandlen

At Your Fingertips

This month's column is devoted to an alphabetical list of resources you can access from your desk. Please don't be shy about notifying me of any corrections or omissions. I know it isn't perfect and am eager to improve it. Send comments to me at **greg@galen.org**.

American Association of Health Plans
The American Association of Health Plans issues a daily newsletter that has more information than you will ever read. A lot of it is company news, medical information, and AAHP information. It also includes policy issues.
Source: **http://www.smartbrief.com/aahp/aahp_sample_f.htm**

American Enterprise Institute
AEI offers two free email newsletters about its own work. "AEI in an Instant" is a biweekly email publication with news of recent and upcoming events, publications, and other activities at AEI. There is also a daily version of that publication, "AEI Today." Send an email requesting a subscription to **kburrows@aei.org**.

Americans for Free Choice in Medicine
Scott Hollaran edits "The Pulse" on behalf of California-based Americans for Free Choice in Medicine (AFCM). This pub includes sections on physician practices, medical savings accounts (MSAs), insurance regulation, hospitals, the drug industry, and others. Each week he also includes a "winners and losers" section that is pretty entertaining. The publication is aimed at members of AFCM but useful to anyone who follows health care issues.
Source: **http://www.afcm.org**

Cato Institute
Tom Miller heads up a team of analysts and researchers that produces policy studies, books, shorter commentaries, conferences, and seminars presenting a libertarian perspective on federal health care reform matters.
Source: **http://www.cato.org**

Citizens' Council on Health Care
Minnesota's Citizens' Council on Health Care, headed by Twila Brase, issues frequent news releases and action alerts, especially on issues such as privacy and patient safety. It also covers reform issues in Minnesota.
Source: **http://www.cchconline.org/**

EBIA Weekly
This one is real dry, but the Employee Benefits Institute of America (EBIA) puts out a weekly newsletter that is must reading for those who want to stay on top of new case law and regulations regarding the Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act (HIPAA), cafeteria plans, and all the other benefits issues. The analysis is clear, well written, and completely objective.
Source:
http://www.ebia.com/weekly/index.jsp

FactCheckers.Org
FactCheckers.org is a cooperative venture of several organizations to rebut misinformation and "bring attention to the hypocrisy of those that advocate single-payer health care systems," according to the Web site. It currently cites reports from Physicians for a National Health Plan, the Center for Budget and Policy Priorities, and Families USA, providing links to articles and commentary on each. This will be an important resource as we enter the wacky period of pre-election posturing and hysteria.
Source: **http://www.factcheckers.org/**

The Heartland Institute
The Heartland Institute publishes *Health Care News* (which you are reading now), featuring a variety of leading lights in the free-market health care reform movement. *HCN* is available as a print or email subscription.

The Heartland Web site also includes a health care issue suite, pulling together back issues of *Health Care News* and hundreds of the best research and commentary documents from other groups addressing health care issues.
Source: **http://www.heartland.org**

The Heritage Foundation
Heritage's Center for Health Policy Studies issues frequent email updates on topics such as the uninsured, Medicare, Medicaid, and state initiatives. It conducts analyses and develops conservative policy prescriptions on such federal health care policy issues as affordability, insurance, and quality-of-care.
Source:
http://www.heritage.org/Research/HealthCare/healthpolicy.cfm

Independence Institute
Colorado's Independence Institute issues a monthly newsletter from its Health Care Policy Center, headed by Linda Gorman. The publication focuses on Colorado, but also deals with national issues. Subscriptions are free.
Source:
http:/www./i2i.org/healthcarecenter.aspx

Medical Tuesday
Dr. Del Meyer puts out a fortnightly publication called "Medical Tuesday." It is a huge body of work that summarizes recent publications of other organizations and has original commentary on single-payer systems, Medicare reform, physician autonomy and a whole lot more. You may subscribe by sending an email to **Info@MedicalTuesday.net**.

National Association of Manufacturers
One of the most entertaining and informative newsletters is by Neil Trautwein of the National Association of Manufacturers. He closely follows what is happening in Washington, especially from a benefits perspective, and covers issues such as mental health parity, flexible spending accounts, health reimbursement arrangements, MSAs, Medicare reform, and so on. He also tracks personnel changes on the Hill and issues alerts on pending legislation. He'll probably put you on his distribution list if you ask nicely. Email him at **ntrautwein@nam.org**.

National Center for Policy Analysis
Almost every issue of NCPA's Daily Policy Digest includes a few health-related stories, though the topics are very wide. It is always well-written, summarizing current studies and news reports, with a focus on economics news. NCPA's Website also contains a large number of studies and reports on market-based health care reform.
Source: **http://www.ncpa.org/sub/**

State Policy Network
State Policy Network is a clearinghouse for free-market think tanks all over the United States. Forty-two states now have active organizations, and some states have more than one. They try to stay focused on state issues, but in health care that includes a lot: MSAs, Medicaid reform, insurance regulation, health planning and certificate of need, state employee benefits, etc. SPN organizes workshops and conferences that bring the local groups together to exchange information and strategies.
Source: **http://www.spn.org/about_spn/**

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Illinois

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Human Services Committee but is now stalled in the Rules Committee.

"I don't think this issue is going to go away," said Senator Barack Obama (D-Chicago), the senate bill's chief sponsor. "This probably won't be dealt with during the fall veto session, but I think it will come back in the next general session in January."

The bill does not describe a specific plan. The HCRC, operating under the auspices of the Illinois Department of Public Health, would develop a plan based on comments from the public. The process would occur over several years and in three stages.

Hearings and More Hearings

In Stage One, the HCRC would hold at least 10 public hearings in different geographic locations around the state over a span of several months. The HCRC, working with an unnamed research firm, would consult with health care providers, health care consumers, and others to assist in the development of the plan.

"Illinois and the rest of the nation already have universal care by requiring hospitals and doctors to provide treatment to persons who need emergency care."

A final report would be presented by the HCRC to the governor and General Assembly on February 1, 2005. The bill says the report shall be based on the public meetings and shall include a comparison analysis of different proposals submitted by interested parties.

In Stage Two of the process, the HCRC would hold 10 more public hearings in different geographic locations to obtain opinions on the proposed plans submitted at the end of Stage One. Those hearings are to be concluded by October 31, 2005.

The bill also requires the commission to ensure that residents throughout the state are informed about the different plan proposals under consideration, including the content of each proposal and the impact each may have on the quality, cost, and availability of health care services.

Stage Three of the measure currently under consideration requires that by February 1, 2006 the HCRC must recommend a plan or plans. The General Assembly must pass enabling legislation for the chosen plan before June 1, 2006. Implementation of the approved plan must occur by January 1, 2007. Those deadlines likely would be adjusted if legislation moves forward in future sessions of the General Assembly.

"The bill was agnostic about what tools might be used to achieve universal care," Obama said. "The commission would determine how to do it. We could adopt a Canadian single-payer option. Or we could adopt a plan like [Congressman Richard] Gephardt's, a mix of expanding Medicaid and providing tax credits to employers. Or it could be something else."

Obama says part of the function of the bill is to spark a debate "to see what we can do at the state level." According to Obama, "After a five-year timeframe, the act would require the General Assembly to at least vote up or down on a recommended means of providing universal health care. Obviously, that is a contentious piece of legislation because there are still significant players in the health care business that are resistant to reform or the notion of universal health care."

Already Universal

One of those players is Dr. William Dam, an Illinois physician and member of the Illinois State Republican Central Committee. Dam said he opposes the legislation and hopes key Republicans and conservative Democrats will work against passage of the bill in the senate.

Dam said that in a sense, Illinois and the rest of the nation already have universal care by requiring hospitals and doctors to provide treatment to persons who need emergency care. He pointed to a colleague of his who recently performed surgery on a man who had no insurance and showed up in a hospital emergency room with life-threatening peritonitis, the result of a burst appendix.

"This was a complex surgery, followed by at least a week in the hospital with intravenous antibiotics," Dam said. "That doctor will get paid not one dollar. There is universal health care. People like this show up for treatment, we provide it and then eat the cost.

"Our legislators are spineless in addressing this issue where it has to be addressed," Dam said. "They're spineless to say, 'We have this much money,' and prioritize. That means an intravenous drug user who's destroyed his liver [should have] to wait behind others to get a liver transplant. Nobody in Illinois has the guts to say that."

Steve Stanek is a freelance writer and contributor to several news sources. His email address is **stanek@mc.net**.

Colorado Passes AHP and Mandate-Lite

by Spencer Swalm, JD, REBC

Sensing Colorado's small group health insurance market was nearing collapse, the state legislature broke a long-standing political logjam to enact several reform measures in 2003.

Aiming to make health insurance more affordable by loosening the mandates that had the small group market tied in knots, the legislature granted carriers limited rating flexibility and permission to sell "mandate-lite" policies. Lawmakers also authorized the creation of association health plans, allowing small employers to band together to enjoy economies of scale.

The centerpiece of the reform effort was H.B. 1164, a dense document sponsored by two legislative heavyweights, House Speaker Lola Spradley and Senate Co-Majority Leader Mark Hillman.

H.B. 1164 started out as Spradley's crusade to make health insurance affordable in her Pueblo district by encouraging the creation of association health plans, also known as Multiple Employer Welfare Arrangements (MEWAs). Recognizing MEWAs have had a troubled track record, Spradley incorporated several consumer safeguards in her bill.

Unfortunately, the bill adopted a strict "community rating" regimen making it unlikely to pass. Community rating requires insurers to charge a single premium for all insureds, regardless of their age, the demographics of their community, lifestyle choices, and health status.

Saving the Day

The politically adept Hillman saved Spradley's measure by hitching his free-market reforms to her MEWA bandwagon late in the session. Hillman's contributions permit small group carriers to price their products based on use: Groups with few claims may qualify for premium discounts up to 25 percent; heavy users, including smokers, may see their rates go up by as much as 15 percent.

House Speaker Lola Spradley

Co-Majority Leader Mark Hillman

With "rate banding," small group carriers have a fighting chance to compete for the healthy, low-cost groups that are necessary to offset the enormous costs associated with the relatively few unhealthy individuals in the population.

Until now, those healthy consumers tended to migrate to less-expensive individual and self-funded plans, where rating flexibility has been permitted all along. The resulting loss of business in the small group market produced large rate increases and a shrinking number of carriers competing for business.

There are encouraging signs that these reforms are already producing the desired results. The measure permits carriers to begin offering 15 percent discounts on September 1, 2003; all have announced their intention to do so. In September 2004, the full 25 percent discount is allowed, as is the 15 percent rate hike for heavy insurance users.

Hillman's amendments to the original MEWA bill also allow carriers to begin selling mandate-lite policies starting January 1, 2004. Such policies empower consumers to decide for themselves whether to pay for procedures like prostate and mammography screenings, rather than having third-party insurance companies decide for them.

Mandate-lite plans are more affordable. For those who don't like them, dozens of other policies containing all state mandates will remain on the market.

The small group reforms embodied in H.B. 1164 were greeted with skepticism by a narrowly divided and partisan legislature. Even with Governor Bill Owens (R) rowing in unison with Spradley and Hillman, the bill's fate was uncertain in the Republican-controlled legislature until the session's final hours.

If reform does nothing more than stabilize small group rates and increase competition by inducing carriers to re-enter the Colorado market, it will have taken an important first step in the right direction.

Spencer Swalm is an employee benefits broker and legislative chair for the Colorado State Association of Health Underwriters. He can be reached at 303/228-1675.

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Privacy

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vidual privacy rights are being protected," the GAO concludes.

The Privacy Act regulates how federal agencies may use the personal information individuals supply when obtaining government services, applying for small business loans, or paying taxes. Provisions of the Privacy Act include minimum necessary data collection, informed consent, maintaining accurate records, safeguarding data, accounting for disclosures, training employees, providing notice for exemptions, and providing remedies and penalties for violations.

Importantly, the Privacy Act places limits only on the collection, disclosure, and use of personal information that is contained in a federal "system of records." A system of records is a collection of information about individuals from which data are retrieved by using the individual's name or other identifying number or code.

Collections of personal information in which data can be retrieved without the use of such identifiers (e.g., through computerized search functions) are not considered to be a "system of records" and are therefore not protected by the Privacy Act.

Two Dozen Agencies Surveyed

In May 2001, at the request of Rep. Joseph Lieberman (D-Connecticut), the GAO began an extensive survey of agency compliance with the Privacy Act and related guidance documents from the Office of Management and Budget (OMB). Participating in the survey were 25 large and small federal departments and agencies, including the Department of Health and Human Services, Department of Commerce, Social Security Administration, and Department of Veterans Affairs. Responses represented about 2,400 systems of records, of which 70 percent were found to contain electronic records.

Although the 82-page GAO report did not include details about specific agency failures to comply with the federal Privacy Act, it provided the following aggregate results for the 2,400 systems of records:

- 11 percent of the systems of records have not been disclosed to the public, meaning individuals do not know such records are being kept about them.
- For 18 percent of the systems, the potential uses of the personal information were not fully disclosed to individuals before they provided that information.
- For 18 percent of the systems, no review of disclosures was made to ascertain whether data are being used outside the original purposes of the data collection.
- For the 29 percent of systems that release data to non-federal organizations, agencies do not assure that personal data on individuals are accurate, relevant, timely, and complete.
- For 18 percent of the systems, agencies did not assess security safeguards for the data.
- 21 percent of the systems have no mechanism for detecting if unauthorized persons are reading, altering, disclosing, or destroying information.
- 14 percent of the agencies could not account for disclosures of personal information.
- One-third (eight) of the agencies have not issued the rules of conduct for employees required under the Privacy Act.

The GAO also found that 83 information systems in use at large agencies during 2002 contained personal information outside a Privacy Act system of records. Because the information could be retrieved without using a name or personal identifier (e.g., by using search codes), it was not protected by the Act. The GAO report suggested additional research is needed to offer a more complete examination of privacy concerns raised by such information systems.

Survey Follow Up

The survey was followed by a February 2003 meeting with representatives, mostly Privacy Act officers, of the 25 agencies. The forum was conducted by the GAO to clarify the results of the survey. Federal Privacy Act officers reported several problems with Privacy Act compliance, among them:

- low priority on compliance within agencies, and therefore inadequate funding for the task; and
- insufficient training, including a lack of information on how the Privacy Act relates to electronic databases.

The OMB is responsible for enforcing the Privacy Act. Despite two previous GAO reports on privacy weaknesses in other activities of federal agencies, and agency requests to the OMB for updated guidance on the Privacy Act pertaining particularly to new technologies, the new GAO report says the OMB has yet to act.

A blistering reply from the Office of Management and Budget is included in the report. In a 10-page letter, the OMB says the report's statements "border on the reckless and irresponsible." The GAO countered with a detailed 13-point rebuttal, concluding again "the government cannot adequately assure the public that all legislated individual privacy rights are being protected."

Public health nurse Twila Brase is president of Citizens' Council on Health Care. Her email address is **twila@cchc-mn.org**. *The Council's Web site is* **http://www.cchconline.org**.

INTERNET INFO

The 82-page June 30 GAO report is available online at **http://www.gao.gov/cgi-bin/getrpt?GAO-03-304**. A one-page summary is available at **http://www.gao.gov/highlights/d03304high.pdf**. Both documents are in Adobe Acrobat's PDF format.

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Maine

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through risk-benefit analysis.

W. Tom Sawyer Jr.

In the case of Dirigo Health, the May 5 proposal first issued by Health Reform for Maine made little sense. The risks were far too great for the rewards. While some 180,000 Mainers would have become eligible for health insurance, and while the federal government might have paid toward insurance coverage for certain employees, especially in small businesses, overall health access would not have been significantly improved by the plan. Moreover, no evidence was offered that the Health Reform for Maine proposal would have improved mortality, longevity, or quality of life.

The downsides included government takeover of the state's largest "industry," the closing of up to eight rural hospitals, an insurance premium tax increase, loss of competing insurance carriers, closure of even more small businesses, further job losses, and rationing of health care services. Similar plans in Kentucky and Oregon had been abandoned.

The reward clearly did not justify the risk.

Politics of Dirigo Health

A Joint Select Committee on Health Care Reform, with four senators and 11 representatives from both major parties, was appointed to tackle the state's health care issues. Members represented the Joint Standing Committees on Appropriations, on Insurance, and on Health and Human Services.

Between May 5 and June 13, many were engaged in discussing L.D. 1611, the Dirigo Health proposal. But some stakeholders felt they had been left out of the process and feared the outcome was a done deal from the beginning. Legislators received a great many calls from fearful teachers and other state employees worried about premium increases. Maine's employer community turned hot, then cold, on the bill. Often, local chambers of commerce took a position on the bill opposite the position taken by the state chamber. The whole process felt too rushed.

Nevertheless, Dirigo Health was passed by the legislature and signed by the governor on June 18. A great many questions remain about the plan's ability to perform as hoped without throwing Maine's health insurance and health care systems into chaos. Will Congress allow the Medicaid "match" for employer payments? Can providers keep cost increases within goals? How many employers will voluntarily sign on? Can hospitals realize a "savings" of $275 million in bad debt and charity care?

Will providers accept reimbursement at reduced rates? Will Anthem Blue Cross and Blue Shield remain in the state? Will insurance premiums go up by 4 percent? Can Dirigo Health achieve its goals with an acceptable expense ratio? Will the finest health care in the world now be rationed to reduce costs?

Why I Voted Yes

Since being elected in 2000, I've tried my best to follow a game plan on issues: to understand the implications of a bill; to listen attentively to all input and debate; to avoid playing politics; and to vote my conscience. When I vote on legislation, I consider my Bangor constituents first; second, the priorities of the Committee of Oversight (Natural Resources); third, the citizens of Maine; and fourth, the Republican Senate caucus.

This bill was complicated. We were being rushed and had proposed we take a final vote on February 1, after all stakeholders had reviewed the final language. The ink was barely dry on the latest challenges. Governor Baldacci was in a pucker to have a vote taken ASAP ... and a vote we would take—four months later.

So, how did I come to vote "yes" in the morning hours of Saturday, June 14? The legislature had been discussing L.D. 1611 since May 5. A great many changes had been made to the original 72-page plan. As a past board member of Maine Blue Cross and Blue Shield and MEMIC insurance companies, I feared L.D. 1611 would do more harm than good. The cure would prove worse than the disease.

During Friday, I sought the input of three key people. They best understood the implications of L.D. 1611; they knew their business; and their opinions could be trusted. In the end, I talked with Senator Karl Turner, ranking Republican senator on the Appropriations Committee; Representative Kevin Glynn, ranking minority member of the Insurance and Financial Affairs Committee; and the lobbyist for Eastern Maine Medical Center, my district's largest employer and a fully engaged party in the Dirigo Health negotiations.

All three advised me to vote yes when L.D. 1611 came to a vote. I had done my best to understand the bill, to remain abreast of its changes, and follow due process.

From the very beginning, Governor Baldacci had enough votes in the legislature to pass the proposal, given the Democratic Party's control of both house and senate. To his credit, he has continually stated he wants to pass legislation on a bipartisan basis, and his willingness to compromise on Dirigo Health during those five weeks is a testament to his following through on a promise. I applaud him for that.

Talking Point

Lee Tooman, vice president of government relations for Golden Rule Insurance Company, told *Health Care News*, "Say what you want about last year's effort in Oregon to pass universal health care—at least you knew what you were voting for. By contrast, Maine's bill represents an awesome delegation of discretionary authority to unelected agency bureaucrats. The bill empowers the government in an unprecedented way to manipulate both the health care delivery and health care financing systems in the state."

I also voted "yes" on the Republican amendment to L.D. 1611, which would have added a high-risk pool for certain insureds—a piece Governor Baldacci should have added to Dirigo Health. (It's not enough to merely oppose legislation. It's vitally important to proffer alternative strategies, and I am pleased we did.) Unfortunately, the amendment failed, and I believe it will come back another year as an important insurance issue.

Only time will tell if Dirigo Health will work or fail. We'll not even begin seeing signs of success or failure until 2004, when Maine has spent the Bush-Collins $54 million tax rebate money and Dirigo must fend for itself.

W. Tom Sawyer Jr. is a Republican state senator from Bangor, Maine. This article was first published by the Bangor Daily News *and is reprinted here with the senator's permission.*

Let us know what you think!
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GALEN INSTITUTE

A MONTHLY REVIEW OF HEALTH POLICY MATTERS

RECENT ARTICLES & STUDIES

Plan Seeks to Give Employees Control over Health Coverage

Peter Neurath
Puget Sound Business Journal
August 11, 2003

Retired admiral and physician Steve Barchet and health-promotion expert Larry Chapman have developed a model health plan called HP4Life, which combines financial incentives for consumers to conserve on health care with 20 programs aimed at promoting health, according to an article in the *Puget Sound Business Journal*.

Barchet and Chapman encourage employers to merge consumer-driven health plans with "health management interventions," including coaching and disease management for employees with multiple health risks, toll-free advice lines, and full employer financing of household health accounts for employees who receive all preventive screening, immunizations, and tests recommended by their doctors. The principal reason for HP4Life, Barchet said, "is to stabilize inevitable increases in health spending and improve the health of the population covered by the plan."

Full text: **http://www.seattle.bizjournals.com/seattle/stories/2003/08/11/newscolumn1.html**

A New Medicaid Program

Lynn Etheredge and Judith Moore
Health Affairs
August 27, 2003

Lynn Etheredge and Judith Moore suggest forming a new federal-state partnership to create an updated Medicaid program because "huge gaps and inequities result from the outdated Medicaid statute, an absence of national standards, and unplanned spending growth."

Etheredge and Moore detail their plan for a new Medicaid that would offer health insurance based on "needs-based" standards and assist working Americans through "Medicaid plus tax credits." The authors also recommend improving the long-term care system for people with disabilities and improving accountability for quality of care.

Full text:
http://www.healthaffairs.org/WebExclusives/Etheredge_Web_Excl_082703.htm

Socializing Drug Development Costs after FDA Approval Is Not Feasible

Jeff Lemieux
Centrists.org
August 23, 2003

Jeff Lemieux of Centrists.org challenges economist Burton Weisbrod's recent oped in *The Washington Post* proposing to socialize pharmaceutical research and development by paying "awards" to drug development firms after FDA approval. Weisbrod suggested taxpayers would pay R&D costs to drug companies, and then the government would take possession of the patents and freely offer them to generic firms willing to produce the drugs.

Lemieux writes that Weisbrod's proposal is not feasible for several reasons: It would be very difficult for the government to decide on the amounts of the awards; if actual costs were used, companies would not be able to recoup costs for drugs that did not succeed clinically; investors would not bet on the possibility of large profits from uncertain government reimbursements; and the government would have to socialize all R&D to keep the drug discovery process alive.

Full text: **http://www.centrists.org/pages/2003/08/22_lemieux_health.html**
Weisbrod's op-ed:
http://www.washingtonpost.com/wp-dyn/articles/A29306-2003Aug21.html

The FDA Warns Cities, States about Buying Canadian Drugs

Anna Wilde Matthews
The Wall Street Journal
August 27, 2003

The FDA took action against California and Massachusetts in an effort to prevent some state and city governments from purchasing Canadian prescription drugs for their employees, writes Anna Wilde Matthews in *The Wall Street Journal*.

In a "strongly worded letter" to California officials, the FDA advised that prescription drugs imported from Canada "will nearly always be in violation of federal law." The city of Springfield, Massachusetts is encouraging its employees to enroll in CanaRx, a program that offers Canadian pharmaceuticals to U.S. customers, which prompted an investigation by the FDA.

Full text (requires subscription):
http://online.wsj.com/article_print/0,,SB106193424282979700,00.html

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, **http://www.galen.org.** *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

Grace-Marie Turner

California liberals are working feverishly to enact an employer mandate requiring businesses to provide health insurance to workers or pay a big tax to fund a new state-run health coverage program. The last thing deficit-plagued California needs right now is a new job-killing tax to fund another multi-billion-dollar government program.

The leader of the state senate, Democrat John Burton, is trying to get his bill enacted and signed by Governor Gray Davis before Davis faces a recall vote.

Locking health insurance even more tightly to employers in a state whose workforce is as highly mobile and technologically savvy as California's is absolutely the wrong way to go, and passage of Burton's measure could set a very dangerous precedent. Empowering health care consumers through tax reform is the better option.

"The Food and Drug Administration (FDA) weighed in on drug reimportation with a stern warning to states and municipalities that have been cooking up their own plans to reimport cheaper drugs from Canada and elsewhere."

On Medicare

Staffers on the Medicare conference committee worked over the August recess to get as much work as possible done before their bosses returned. It was evident how tricky those negotiations will be as rural health care again became a stumbling block: Senator Chuck Grassley pulled his staff from the talks because he didn't feel his issues were getting sufficient attention.

The conferees also will be forced once again to face drug reimportation. Furor over the issue did die down during the August recess, and Representative Gil Gutknecht (R-Minnesota) and his allies, fresh from a series of townhall meetings, will push to include in the final Medicare bill his plan to legalize drug reimports from 26 countries.

The Food and Drug Administration (FDA) weighed in on drug reimportation with a stern warning to states and municipalities that have been cooking up their own plans to reimport cheaper drugs from Canada and elsewhere.

I believe the tipping point leading to House passage of drug reimportation legislation in July was the growing awareness other rich countries—France, Germany, and Canada among them—pay little toward research and development costs, pushing the bulk of the burden onto U.S. consumers.

Americans are growing angry, especially since those who usually wind up paying the highest prices are seniors without drug coverage or someone to negotiate discounts on their behalf.

As much as anything, legislators wanted to send a wake-up call to the pharmaceutical companies to fix this problem. But the companies are over a barrel: Most countries have "compulsory licensing" laws that allow them to violate patent protection and copy the drugs if the companies don't agree to the price-controlled rates the governments offer.

The pharmaceutical companies have a strong incentive to go along with these deals, since protecting their intellectual property rights is the lifeblood of their industry. The solutions will involve complex issues of international trade to empower a tough new bargaining stance by the companies.

Grace-Marie Turner

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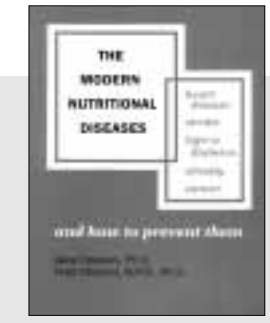
BOOK **REVIEW**

by Dr. Jay Lehr, Ph.D.

Feel Better, Live Longer

The Modern Nutritional Diseases: and How to Prevent Them

by Alice Ottoboni, Ph.D. and Fred Ottoboni, M.P.H., Ph.D.
Vincente Books, Inc.
paperback, 224 pages



Without completely giving away their ages, I can testify that this dynamic duo of health science, Fred and Alice Ottoboni, have more than a century of collective experience in this field, with numerous brilliant publications to their credit. But their best work was ahead of them ... and this book is it.

The Modern Nutritional Diseases culminates a three-year study of the current government-sponsored wisdom on diet, nutrition, and disease ... and meticulously turns that research on its ear.

The easy prose of some of its 10 chapters make it great reading for the layman, while the precise breakdown of the body's biochemical reactions to food intake will satisfy the true rocket scientists interested in nutrition.

It is not unusual nowadays to see family members and friends taking costly prescription drugs or being hospitalized for such illnesses as heart attack, stroke, or cancer. At the same time, a day seldom passes without some message in the news media from nutrition and government agencies advising that these same health problems can be prevented—or even cured—by a heart-healthy diet. This recommended diet severely restricts red meat, eggs, butter, and saturated fat and promotes low-fat, low-cholesterol foods plus an abundance of grain-based breads, cereals, and polyunsaturated vegetable oils.

The national education program touting the diet for heart disease prevention began about a half-century ago. The great increases in sales of low-fat, low-cholesterol, and high-carbohydrate foods and polyunsaturated vegetable oils that have resulted since then is good evidence that this public education program has been very effective. Today, millions of Americans are following this diet.

Yet national health statistics show that attack rates of cardiovascular diseases and a number of other chronic conditions, including high blood cholesterol, high blood pressure, stroke, and type-2 diabetes, have been steadily increasing.

"The Ottobonis' research clearly indicates what many have long believed: that lifestyle and nutrition, not genetics or luck, are the most powerful factors affecting health and well-being."

The Ottobonis' research clearly indicates what many have long believed: that lifestyle and nutrition, not genetics or luck, are the most powerful factors affecting health and well-being. They learned that popular notions concerning the adverse health effects of dietary fats and cholesterol, which were the foundation of the heart-healthy diet, were not based on scientific facts. What they read in the popular press was not what they read in the scientific literature.

Published epidemiological, biochemical, and dietary studies did not support the idea that the heart-healthy diet prevented heart disease, stroke, high blood pressure, or hypercholesterolemia.

It may please some and frustrate others to learn that a number of previous authors, who were castigated for their outspoken and commercial efforts to paddle upstream in the nutrition debate, appear to have been correct all along.

The Ottobonis praise the highly technical explanations of Barry Sears in his books *Enter the Zone* and *The Anti-Aging Zone*. His studies of the biochemistry of lipids and essential fatty acids provide the background for how macronutrients and essential fatty acids affect the body's most important biochemical processes. His unique contribution to nutritional biochemistry has been to trace the complex biochemical relationships among proteins, fats, carbohydrates, insulin levels, and essential fatty acids and then explain how diet can both cause and prevent disease.

Similarly, they praise the late Robert Atkins' final book, *New Diet Revolution*, based on his years of clinical practice treating obesity and its related diseases.

The Ottobonis' work is not an opinion piece, but rather the scientific proof for what in our diet makes us well or unwell. You will not find any radical ideas about diet and health. Rather, you may learn that what our parents considered a healthy diet was indeed just that. The authors recommend a 40-30-30 balance of carbohydrates, protein, and fat, with a positive emphasis on animal protein and animal fat.

The Ottobonis are strong believers in vitamin supplementation with all conventional ingredients of your drug store's daily vitamin packet. Plus some solid evidence that less-common reliance on a few ingredients like flaxseed oil, lecithin, MSM, and CoQ10 might really be useful to our bodies.

The information in this book should help you feel better, live longer, avoid the modern nutritional diseases, and be happier and more active as you grow older. The ideal is to keep all systems functioning well, until the point when everything wears out and fails all at once.

Jay Lehr, Ph.D. is science director for The Heartland Institute and living testimony to the importance of lifestyle and nutrition to good health. At age 67, Lehr is "ramping up" his life, spending four hours a day in his own training and recently becoming a certified professional trainer of others. Lehr has completed the Hawaiian Ironman Triathlon Championship in Kona nine times and has more than 1,200 skydives to his credit. He recently attempted a rim-to-rim double hike across the Grand Canyon, had to be airlifted out, and three weeks later succeeded in bicycling across the Rocky Mountains.

The Modern Nutritional Diseases and How to Prevent Them

by Alice Ottoboni, Ph.D., and Fred Ottoboni, M.P.H., Ph.D

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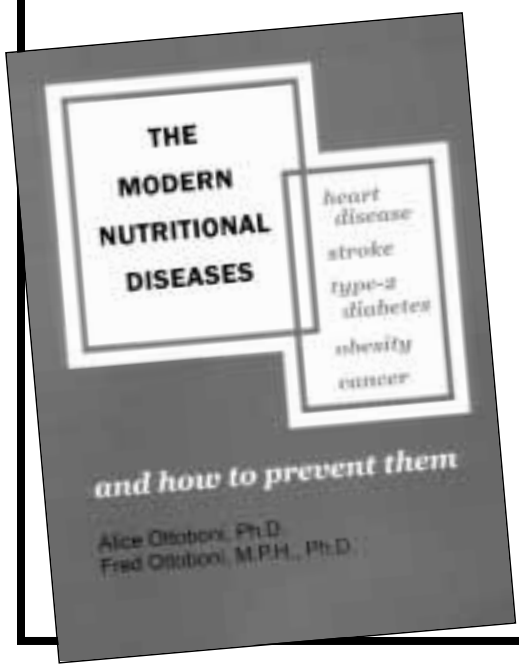

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